CHILDREN WITH SPECIAL HEALTH NEEDS (CSHN)

Admission Questionnaire
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Program:	Date:	Region (1-4):
H'Hold ID Number: _____		Patient ID: _____

(For Department Use Only)

I. CHILD-FAMILY INFORMATION

Child's Name: _____ _____
First Middle Last Date of Birth

With whom does child live? ___Parent(s) ___Guardian ___Relative ___Foster Parent ___Other

Primary Contact Person: _____
First Name Initial Last Name

_____ _____ _____
Sex(M/F) Social Security Number (Optional unless on Medicaid) Birthdate

Telephone (home): _____ OK to call at work? ___Yes ___No Telephone (work) _____

_____
Employer's name

Additional Telephone Numbers (If there is someone else whom we might contact, or with whom we might leave a message.)

Number:	Message (Check 1 box.)	Work (Check 1 box.)	Name:
_____	☐	☐	_____
Number:	Message	Work	Name:
_____	☐	☐	_____

Mailing Address: _____
(Street/Box number)

_____
(City) (State) (ZIP)

Town of Residence: _____ Directions to child's home: _____

_____

Please list all household members below. Please include information about the child or children being enrolled.

First Name	Middle	Last	Sex M/F	S.S. Number (Optional unless receiving Medicaid)	Relationship to primary contact person	Birthdate (mm/dd/yy)

The information above will help us to let you know about the full range of services that may be available to you and your family.

II. SERVICE INFORMATION

It is helpful to know about the history of your child's special health needs and the services she/he has already received. With your written permission we may request some of the records to help us better care for your child through CSHN.

Vermont Department of Health

Does your child (or any family member) receive other health department services?
(Please indicate "C" for CHILD, and "F" for FAMILY MEMBER.)

___ Well Child Clinics

___ Child Development Clinic

___ Handicapped Childrens' Services (our old name)

___ Public Health Nursing

___ Partners in Health

___ WIC

Hospitals

Your child's birth hospital _____
Name of hospital

_____
Address, if known

II. Continued

Other hospitalizations

Hospital	Address	Approximate Date	Reason for Admission

Surgeries, Tests, and Procedures, not already listed

Please list any surgical procedures, tests, and evaluations your child has had, as well as approximate dates, locations, and doctors involved.

Date	Location	Procedure

Doctors

It is helpful for us to know about any other evaluations, services, or medical care your child has had. Please list below any such services that you have not already told us about.

Doctor's Name	Address	Approximate Date of Last Visit

Education Programs and Schools

Please list the education programs (Early Education, schools, etc) your child has attended, and the dates.

School/Program	Address	Dates

I. Continued

Other Service providers/Agencies

Please list any other services your child has been involved with, the services received, and the dates.

Service Provider/Agency	Services	Dates

Additional Information

Please use this space for any additional information that you may wish to share.

II. REFERRAL INFORMATION

Who referred your child to CSHN, and why?

What are your main concerns about your child?

IV. INSURANCE INFORMATION

Is your child covered by medical insurance? ___ Yes ___ No

If yes, please complete the following.

Primary Insurance	Is this a MANAGED CARE plan? Yes No

Policy Holder (Insured person's name) _____

Insurance Company: _____

Policy/Certificate Number: _____

Group Number: _____

Secondary Insurance, if applicable	Is this a MANAGED CARE plan? Yes No

Policy Holder (Insured person's name) _____

Insurance Company: _____

Policy/Certificate Number: _____

Group Number: _____

Is your child covered by Medicaid? ___ Yes ___ No ___ Applied

Is your child covered by the Dr. Dynasaur program? ___ Yes ___ No ___ Applied

Child's Medicaid Number: _ _ _ - _ _ _ - _ _ _ _ _

Is this a Medicaid MANAGED CARE Plan? ___ Yes ___ No

Is your child eligible for S.S.I.? ___ Yes ___ No ___ Applied

I understand that CSHN may share information sufficient to process claim(s) for reimbursement with my insurance company.

Signed: _____ Date: _____

Do you have questions?

Contact CSHN at the address below, or call 1-800-660-4427 (863-7338 within Chittenden County)
To call the Child Development Clinic, dial 1-800-640-4232 (863-7315 within Chittenden County)

Please return this completed form to :